



Idaho State Board of Pharmacy

3380 Americana Terrace #320
208/334-2356

PO Box 83720
208/334-2356

Boise ID 83720-0067
208/334-3536 Fax

CONTINUING EDUCATION PROGRAM REQUEST FOR APPROVAL

INCOMPLETE FORMS WILL NOT BE PROCESSED

Office Use Only

Approved for _____ CEU's

Signature _____

Fee: _____
Date _____

REQUEST MUST BE SUBMITTED 30 DAYS PRIOR TO PROGRAM DATE

APPLICANT INFORMATION

Name of person applying for credit: _____

Phone: _____ Fax: _____

(Approval form will be returned by fax if provided)

Address: _____
Street City St Zip

PROGRAM INFORMATION

Drug Company & Rep (if applicable): _____

Phone: _____ Fax: _____

Title: _____ Contact Hours: _____

60 minutes actual = 1 contact hour

Date: _____ Time: _____

Location: _____
Include address

Program Registration Open to: _____ Fee: _____

PRESENTER INFORMATION

Name & Qualifications of Instructor(s): _____

Description of Subject Matter *(Include goals & objectives)*: _____

Method of program evaluation: _____

Signature of Applicant: _____ Date: _____

CERTIFICATE OF ATTENDANCE MUST BE PROVIDED